Final Settlement, Group I

There is no financial risk for facilities participating in this group. The baseline amount for this group is the statewide standard per diem of $5.85. Settlements at the end of the pilot period will be based on: payments to vendors during the pilot; the statewide standard per diem ($5.85); and the facility specific rate (FSR). The methods for settlement will be:

1. if vendor payments are less than the FSR but are greater than $5.85 (SSPD), the Division will pay the facility 25% of the difference between their FSR and actual vendor payments; or
2. if vendor payments are less than $5.85 (SSPD), the Division will pay:
   a. the amount calculated in (1) above, plus 50% of the difference between $5.85 and the actual vendor payments up to $2.93 (50% of $5.85); or
   b. if vendor payments exceed the FSR there will be no settlement with the facility.

Final Settlement, Group II

The baseline amount for this group is the amount equal to the facility specific rate (FSR). Final settlement will be based on the difference between vendor payments and the baseline amount (FSR). The methods for settlements will be:

1. if vendor payments are less than the FSR, down to and including 50% of that amount, the Division will pay the facility an amount equal to 50% of the difference; or
2. if vendor payments exceed the FSR, up to and including 150% of that amount, then the facility will reimburse the Division for 25% of the difference between that amount and the actual vendor payments.

Reconciliation and settlement through this approach effectively cap both the downside and upside financial exposure for facilities. Risk is capped at 12.5% of the FSR. Return is capped at 25% of the FSR.

Special Conditions

For ancillaries that are provided by the facility itself there will be no payment to the facility or to special vendors. These are services the facility decides to make rather than buy or to make special contracts with vendors for fees below levels in the MassHealth rate schedule. These amounts will not be considered part of the incurred vendor payments. This means that the facility and the Division will share in the reduction of vendor payments that may result from such arrangements. For these situations the facility will:

1. notify the Division (Lisa McDowell) in writing of the changes being made and the affected services; and
2. segregate the costs incurred in providing the goods and services.

Settlement examples and grids for both groups can be found in Attachments B and B1.

Timing and Duration

The pilot project will run from October 1, 1998, through June 30, 1999. The project sample will constitute those residents in the facility on October 1, 1998, and those admitted to the facility between October 1, 1998, and March 31, 1999. The data collection period will run from October 1, 1998, through June 30, 1999, allowing all residents to be tracked for the duration of their stay or for three months, whichever is shorter. The final evaluation activity will occur from July 1, 1999, to September 30, 1999.

Evaluation Protocols

The evaluation will rely on facility pre- and post-pilot comparisons and comparisons with all nonparticipating facilities. The intent is to describe outcomes and issues of the administrative feasibility of bundled payment. The issues that will be examined include changes and/or differences in:

1. MassHealth payments for ancillaries, and for all health care taken together for patients served under the participating groups;
2. prescribing patterns and frequency of key, necessary therapies and pharmaceuticals, and the appropriateness of this care (including treatment for secondary conditions);
3. frequency and patterns of admission for persons with high ancillary costs or heavy care needs; and
4. corroborating evidence of changes in clinical and administrative decision making.

Evaluation Data Needs

Several types of data will be needed to answer the evaluation questions. These data include the following.

1. Medical records data.
2. MDS/MMQ data.
3. Claims and payment data for study patients. (Claims data in the baseline and post period will be provided by the Division.)
4. Qualitative management information — intensive case studies at 10-12 facilities. (These administrative studies will require two or three site visits each in order to document the changes in clinical and administrative decision making regarding ancillaries and the nature of in-house controls and physician interactions. It is also likely that the qualitative data collection will include focus groups or direct interviewing of persons conducting discharge planning in selected hospitals to determine if there are patterns of restricted access (difficult placement) for certain types patients in pilot facilities.)
5. Tracer conditions – selected conditions where pilot effects are expected to be most pronounced or most interesting.

Selection Criteria

The selection of facilities to participate in the pilot project will be determined by the Division. At a minimum, facilities must meet the following criteria in order to be considered for participation in the pilot project.

1. Capacity of 60 or greater beds.
2. Facility-specific ancillary costs per patient day between $1.17 and $11.70 (See Attachment C).
3. No significant changes in facility operations since 1996 including, but not limited to: mission, licensure, and casemix.
4. No substandard quality of care issues identified by the Department of Public Health that may impact participation and/or outcomes of the study.

Obligations of Participants

Facilities that are selected to participate will agree to:

1. remain in the pilot for the duration of the project;
2. provide all necessary data including MDS on patients;
3. provide access for medical-record reviews;
4. allow interviews and observation by evaluators;
5. notify the Division of special arrangements for ancillaries; and
6. retain associated cost information.

Applications

Facilities that meet the minimum participation requirements and that are interested in applying should complete the Application Form found in Attachment D. The deadline for the receipt of applications is August 31, 1998. Send your applications to:

Lisa McDowell
Division of Medical Assistance
600 Washington St.
Boston, MA 02111

ATTACHMENT B.

SETTLEMENT EXAMPLES

Group I. Standard Rate Model. *State Standard Per Diem(SSPD) $ 5.85*	*Facility and Risk/Share Information*
Historical ancillaries for this facility:	**$6.00 PPD** (Per Patient Day)
Rate allowed for this facility	**$5.85** (within the group of NF's paid the SSPD)
Limit on payments for profit sharing	**$2.93** (50% of the standard rate)
Retrospective Settlement:	
If payments to vendors are **$2.50** then state pays facility	50% * $2.93 = **$1.47**plus 25% *($6.00-$5.85=$0.15)= **$.038** Total Settlement: **$1. 50 PPD**
If payments to vendors are **$4.50** then state pays facility	50% *($ 5.85-$4.50 = $1.35) = **$.68** plus 25%* ($6.00-$5.85 = $0.15) = **$.038** Total Settlement: **$.71 PPD**
If payments to vendors are **$5.50** then state pays facility	50% * ($5.85-$5.50=$0.35 = **$.175** plus 25% * ($6.00-$5.85=$0.15) = **$.038** Total Settlement: **$.21 PPD** .
If payments to vendors are **$5.75** then state pays the facility	25%*($ 6.00-$5.75=$0.25) = **$.063** Total Settlement: **$.063 PPD**
If payments to vendors are **$6.95**	**No Settlement**

Group II. Outlier Rate Model. *State Standard Per Diem(SSPD) $ 5.85*	*Facility and Risk/Share Information*
Historical ancillaries for this facility:	**$5.00 PPD**(Per Patient Day)
Rate allowed for this facility	**$5.00** (facility specific rate)
Limit on payments for profit sharing	**$2.50** (50% of the facility specific rate)
Limit on payments for loss sharing	**$7.50**
Retrospective Settlement:	
If payments to vendors are **$2.50** then state pays facility	50% * ($2.50)= **$ 1.25(the limit)** Total Settlement: **$ 1.25**
If payments to vendors are **$4.50** then state pays facility	50% * ($ 5.00-$4.50 = $.50) = **$.25 PPD** Total Settlement: **$.25 PPD**
If payments to vendors are **$5.75** then facility pays the state	25% * ($5.75-$5.00=$.75) = **$.19** Total Settlement: **$.19 PPD**
If payments to vendors are **$ 8.50** then facility pays the state	25% * ($2.50)= $ **.63 (the limit)** Total Settlement: $ **.63 (the limit) PPD**

ATTACHMENT B1

STANDARD PAYMENT MODEL

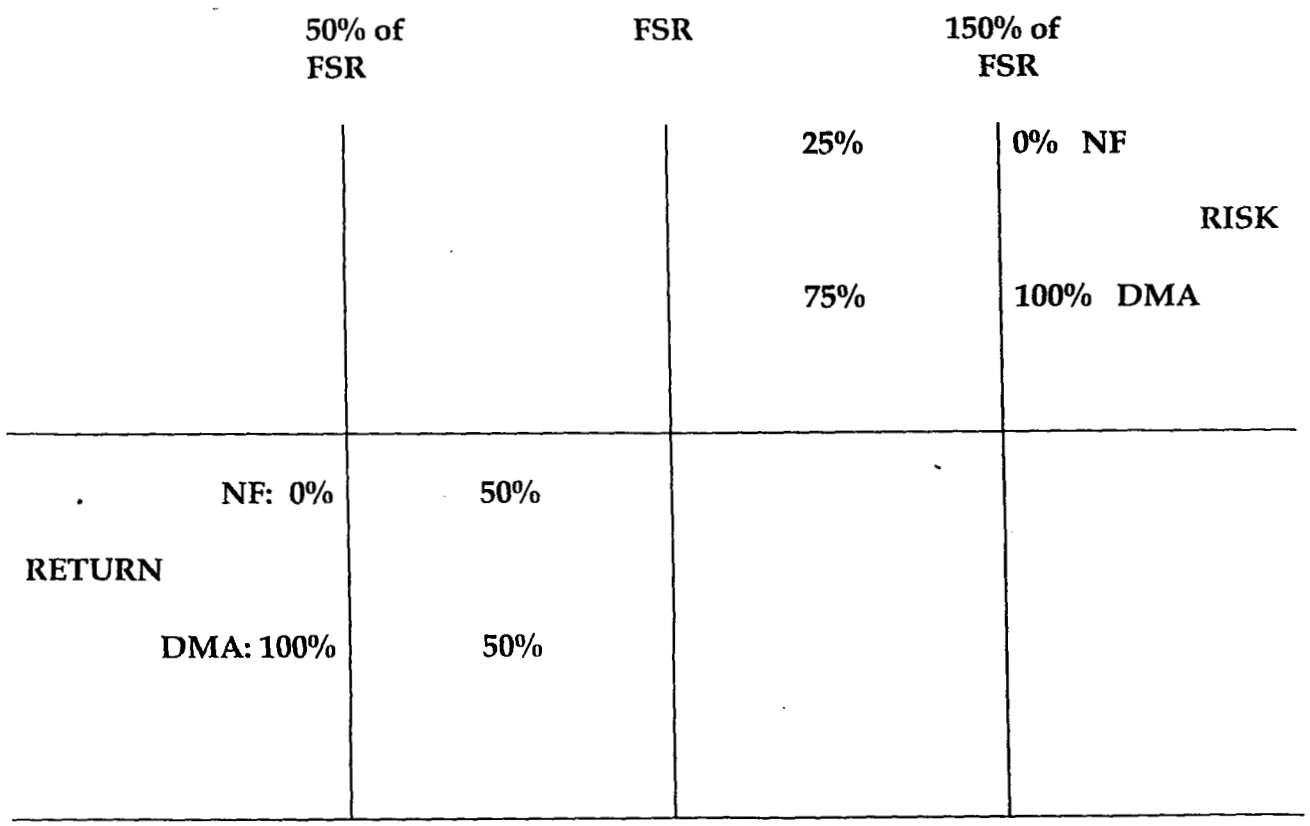
	$2.93 (50% SSPD)	$5.85 (SSPD)	FSR BASELINE	$7.02
			0%	0% NF RISK
			100%	100% DMA
NF: 0%	50%	25%		
RETURN				
DMA: 100%	50%	75%		

SETTLEMENT SHARES

OFFICIAL

ATTACHMENT B2

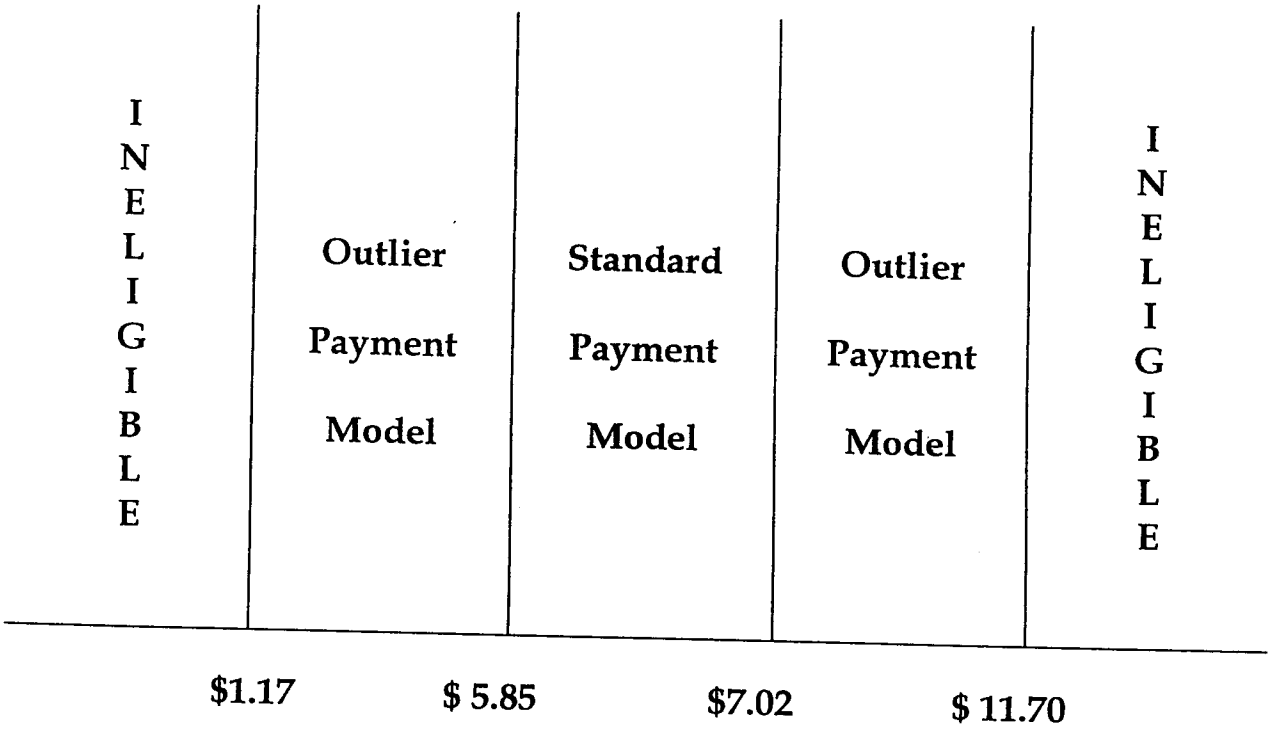
OUTLIER PAYMENT MODEL



SETTLEMENT RISK SHARES

ATTACHMENT C.

FACILITY'S PILOT PARTICIPATION STATUS



HISTORICAL ANCILLARY COSTS

ATTACHMENT D

APPLICATION FOR PARTICIPATION

PARTICIPANT INFORMATION

FACILITY NAME	
STREET	
CITY	
STATE	
ZIPCODE	
VPN	
TOTAL # BEDS	

PILOT INFORMATION

PAYMENT GROUP	_____ STANDARD _____ OUTLIER
BASELINE AMOUNT	$

OFFICIAL

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

Section

6.01: General Provisions

(1) Scope and Effective Date. 114.2 CMR 6.00 governs the payments effective January 1, 2000 for services rendered to Publicly-Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility.

(2) Authority. 114.2 CMR 6.00 is adopted pursuant to M.G.L. c. 118G.

6.02: General Definitions

As used in 114.2 CMR 6.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 6.00 are capitalized.

ACE Group. The Audit, Compliance and Evaluation Group of the Division of Health Care Finance and Policy.

Actual Utilization Rate. The occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units which may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical,; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs. For facilities organized as sole proprietors or partnerships and for which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits, administrative and general costs shall include an imputed value of $69,781 to reflect the costs of such services.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Building. Building Costs include the direct cost of construction of the structure that houses residents and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures that are made a permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Capital Costs. Capital Costs include Building Depreciation, Financing Contribution, Building Insurance, Real Estate Taxes, non-income portion of Massachusetts Corp. Excise Taxes, Other Rent and Other Fixed Costs.

Case-Mix Category. One of six categories of resident acuity that represents a range of Management Minutes.

Change of Ownership. A bona fide transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the Provider rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g. drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Department. The Massachusetts Department of Public Health.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to the Building, including such items as beds, tables, and wheelchairs .

Financing Contribution. Payment for the use of necessary capital assets whether internally or externally funded.

Hospital-Based Nursing Facility. A separate Nursing Facility Unit or Units located in a hospital building licensed for both hospital and Nursing Facility services in which the Nursing Facility licensed beds are less than a majority of the facility's total licensed beds and the Nursing Facility patient days are less than a majority of the facility's total patient days. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the Provider's increased productivity, greater capacity or longer life.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, et seq.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Major Addition. A newly constructed addition to a Nursing Facility which increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the Division of Medical Assistance.

Massachusetts Corporate Excise Tax. Those taxes which have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed beds for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A Provider's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) that are necessary to obtain Long-Term financing through a mortgage, bond or other Long-Term debt instrument.

New Facility. A Nursing Facility that opens on or after January 1, 2000. A Replacement Facility is not a New Facility.

Nursing Costs. Nursing costs include the 1998 Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, and the Workers Compensation expense, Payroll Tax expense, and Fringe Benefits, including Pension Expense, associated with those salaries.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, s.71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Other Fixed Costs. Other Fixed Costs include Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment, the Non-Income portion of the Massachusetts Corporate Excise tax, Building Insurance, and Rental of Equipment located at the facility.

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical Director; Advisory Physician; Utilization Review Committee; Employee Physical Exams; Other Physician Services; House Medical Supplies Not Resold; Pharmacy Consultant; Social Service Worker; Indirect Restorative and Recreation Therapy Expense; Other Required Education; Job Related Education; Quality Assurance Professionals; Management Minute Questionnaire Nurses; Staff Development Coordinator; Motor Vehicle Expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General Costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a Provider reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the Division of Medical Assistance. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Private Nursing Facility. A Nursing Facility that does not have a provider agreement with the Division of Medical Assistance to provide services to publicly-assisted Residents.

Provider. A Nursing Facility providing care to Publicly-Aided Residents or Industrial Accident Residents.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly-Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Rate Year. The calendar year in which the standard payments are in effect.

Related Party. An individual or organization associated or affiliated with, or which has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Replacement Facility. A Nursing Facility licensed prior to January 1, 2000 that replaces all of its beds and/or its entire building pursuant to an approved Determination of Need under 105 CMR 100.505(a)(6).

114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed in Schedules 13 and 14 of the 1998 cost reports.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility which has been licensed by the Department to provide residential care.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

6.03: Nursing

(1) Nursing Standard Payments. New Facilities and Hospital-based Nursing Facilities will be paid at the Nursing Standard Payments. The Nursing Standard Payments are:

Payment Group	Management Minute Range	Standard Payment
H	0 - 30	9.81
JK	30.1 – 110	21.96
LM	110.1 – 170	46.43
NP	170.1 – 225	64.74
RS	225.1 – 270	81.28
T	270.1 and above	98.66

(2) Nursing Transition Payments. All facilities except New Facilities and Hospital-Based Nursing Facilities will be paid Nursing Transition Payments.

(a) Determination of Facility Rates. For each facility, the Division will calculate six case mix adjusted nursing rates.

1. Allowable Nursing Cost per Management Minute. The Division will determine a facility's Allowable Nursing Costs as follows:

a. 1998 Actual Nursing Cost per Management Minute. A facility's Actual Nursing Cost per Management Minute is the sum of its reported Nursing Costs divided by the greater of (1) 96% of the current Licensed Bed Capacity for 1998 times 365 or (2) actual 1998 patient days, divided by the facility's 1998 average Management Minutes.

b. Determination of Nursing Ceiling. The Division will calculate a Nursing Ceiling based upon reported 1998 average nursing cost per management minute as follows:

i. The Division will calculate a nursing per diem for each facility by dividing the facility's claimed 1998 nursing costs by the greater of 1998 patient days or 96% of the Mean Licensed Bed Capacity in 1998 times 365.

ii. The Division will calculate the 1998 average nursing cost per Management Minute for each facility by dividing the 1998 nursing cost per diem by the facility's 1998 average Management Minutes.

iii. The Nursing Ceiling is 110% of the median claimed 1998 average Nursing Cost per Management Minute, or $0.343 per Management Minute.

c. Allowable Nursing Cost per Management Minute. A facility's Allowable Nursing Cost per Management Minute is the lower of its 1998 Actual Nursing Cost per Management Minute or the Nursing Ceiling.

2. Calculation of Six Nursing Per Diem Rates. The Division will multiply the allowable nursing cost per management minute by the facility's average management minutes per case-mix category to obtain a per diem rate for each category. If the facility-specific mean minutes per payment group equals zero, the Division will use the industry median minutes for that category. The Division will apply a Cost Adjustment Factor of 4.78% to the six weighted nursing per diem rates.

(b) Nursing Transition Payments.

1. The Division will calculate two weighted Nursing Per Diem Rates for each facility using third quarter 1999 case mix data. If 1999 case mix data is not available, the Division will use the best available data.

a. The first weighted rate will equal the sum of the products of (1) 33.3% of the Facility Rate plus (2) 66.7% of the Standard Payment for each nursing category times the corresponding case mix proportion.

b. The second weighted rate will equal the sum of the products of (1) 50% of the Facility Rate and (2) 50% of the Standard Payment for each nursing category times the corresponding case mix proportion.

2. If the first weighted rate is higher than the second weighted rate, the Nursing Payments for Payment Groups JK to T will be the sum of (a) 33.3% of the Facility Rates and (b) 66.7% of the Standard Payments for Nursing.

3. If the first weighted rate is lower than the second weighted rate, the Nursing Payments for Payment Groups JK to T will be the sum of (a) 50% of the Facility Rates and (b) 50% of the Standard Payments for Nursing.

4. The Nursing Payment for Payment Group H is the Nursing Standard Payment of $9.81.

6.04: Other Operating Costs.

(1) Other Operating Cost Standard Payments. New Facilities and Hospital-based Nursing Facilities will be paid at the Standard Payments. The Other Operating Cost Standard Payment for each Payment Group is $53.52.

(2) Other Operating Cost Transition Payment. All facilities except New Facilities and Hospital-Based Nursing Facilities will be paid Transition Payments.

(a) Determination of the Allowable Other Operating Costs. The Division will determine the facility's Allowable Other Operating Costs per diem as follows:

1. The Division will subtract the facility's reported 1998 Administrative and General expenses from reported 1998 Other Operating expenses to obtain Net Other Operating Expenses.
2. The facility's Net Other Operating Expenses per day is equal to Net Other Operating Expenses divided by the greater of
    a. 96% of the mean Licensed Bed Capacity in 1998 times 365, or
    b. actual patient days.
3. The facility's Allowable Administrative and General per diem is equal to the lower of
    a. reported 1998 Administrative and General expenses divided by the greater of
        i. 96% of the mean Licensed Bed Capacity in 1998 times 365, or
        ii. actual patient days, or
    b. the Administrative and General ceiling of $11.48 per day.
4. The sum of the facility's Net Other Operating Expenses per day and its Allowable Administrative and General per diem equals the facility's preliminary Other Operating Cost per diem.
5. The Division will calculate an Other Operating Cost Ceiling as follows:
    a. The Division will calculate the 1998 Other Operating Cost per diem for all facilities.
    b. The Other Operating Ceiling equals the industry median plus 6%, or $54.14.
6. A facility's Allowable Other Operating Cost is the lower of its preliminary Other Operating Cost per diem or the ceiling.
7. The Division will apply a Cost Adjustment Factor of 4.78% to Allowable Other Operating Costs.

(b) Other Operating Cost Transition Payment.

1. The Other Operating Cost Payment for Payment Groups JK through T will be the sum of (a) 33.3% of the facility's Allowable Other Operating Costs, adjusted for inflation, and (b) 66.7% of the Other Operating Standard Payment.
2. If the sum of (a) 50% of the facility's Allowable Other Operating Costs, adjusted for inflation, and (b) 50% of the Other Operating Standard Payment is greater than the amount calculated in 6.04(2)(b)1, the Other Operating Cost Payment for Groups JK through T will be the the sum of 50% of the facility's Allowable Other Operating Costs and 50% of the Other Operating Standard Payment.
3. The Other Operating Cost Payment for Payment Group H is the Standard Payment, $53.52.

6.05 Capital

(1) Capital Payment. The payment for Capital Costs will be $17.29 per day for:

(a) facilities and licensed beds that become operational on or after February 1, 1998 and which are:

1. New Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;
2. Replacement facilities which are replaced pursuant to a Determination of Need approved after March 7, 1996,
3. New Facilities constructed in Urban Underbedded areas exempt from the Determination of Need process;
4. New beds licensed pursuant to a Determination of Need approved after March 7, 1996; and

5. New beds in twelve-bed expansion projects not associated with an approved Determination of Need project.

(b) Hospital-Based Nursing Facilities; and

(c) Private Nursing Facilities which sign a Provider Agreement with the Division of Medical Assistance during the Rate Year.

(2) Capital Payment – Other Facilities. For all other facilities, the Capital Payment is based on the facility's Capital Costs, including allowable depreciation, Financing Contribution, and Other Fixed Costs. (a) Allowable Basis of Fixed Assets.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.

2. Allowable Basis. The Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council and used for Nursing Facility services. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.

3. Allowable Additions. The Division will recognize Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure, the allowable amount will be limited to the amount approved by the Department. The Division will not recognize Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

4. Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

a. Land. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis.

b. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June, 30, 1976 and 1993 forward.

c. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

d. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

e. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

f. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

5. Special Provisions.

a. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

b. Repossession by Transferor. The Division will recalculate Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership , increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

(b) Capital Costs. The Division will calculate the Provider's Capital Costs including depreciation, Financing Contribution, and Other Capital Costs as defined below.

1. Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets as of December 31, 1998. Depreciation of Buildings, Building Improvements, and Equipment will be allowed based on generally accepted accounting principles using the Allowable Basis of Fixed Assets, the straight line method, and the following useful lives:

LIFE	YEARS	RATE
Buildings and Additions	40	2.5%
Building Improvements	20	5%
Equipment, Furniture and Fixtures	10	10%
Software	3	33.3%

2. Financing Contribution. The Division will calculate a Financing Contribution by multiplying 7.625% by the Allowable Net Book Value as of December 31, 1998. The Allowable Net Book Value is the allowable basis less all accumulated depreciation calculated for the period through December 31, 1998, except allowed Building depreciation expense which occurred between January 1, 1983 and December 31, 1992.

3. Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment at the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

4. Capital Costs. The Division will calculate the Provider's Capital Costs by adding allowable 1998 depreciation and Other Fixed Costs and the Financing Contribution.

5. Capital Cost Per Diem. The Division will calculate the Provider's 1998 Capital Cost per diem by dividing 1998 Capital Costs by the greater of 96% of Constructed Bed Capacity times 365 or the Actual Utilization Rate in 1998.

6. For Providers with a revised 1999 Capital Payment for a substantial capital expenditure, the Division will calculate Capital Costs using the December 31, 1999 Allowable Basis and Net Book Value, 1999 constructed bed capacity, and 1999 Actual Utilization Rate. This does not apply to providers whose revised Capital Payment was $17.29.

(c) Determination of Capital Payment.

1. If the Provider's 1999 Capital Payment is lower than $17.29, and its Capital Cost per diem is greater than $17.29, its 2000 Capital Payment will be $17.29.

2. If the Provider's 1999 Capital Payment is lower than $17.29, and its Capital Cost per diem is lower than $17.29, its 2000 Capital Payment will be its Capital Cost per diem.